STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255320	A. BUILDING _____ B. WING _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHAB CENTER	100 LAUREN DRIVE BOONEVILLE, MS 38829

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 4/01/24 through 4/04/24. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F583, F623, F656 and F880. The census at the time of survey was 71 and the facility is licensed for 80 beds.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure	F 583		5/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/15/2024

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F 583	Continued From page 1 and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review the facility failed to secure electronic health records as evidenced by an Electronic Medication Administration Record (EMAR) was visible while the medication cart was unattended on the Alzheimer's unit for one (1) of 16 residents residing in the unit. Resident #66 Findings Include: Review of the facility policy with a revision date of 11/28/2017 titled "Confidentiality of Information" revealed, "This facility shall maintain an individual's right to privacy and confidentiality of information ... Confidentiality of the resident record shall be maintained at all times by keeping the record closed when not in use. If an electronic health record is used, ensure that no other individual can read the screen and log-off the computer when not in use." An observation on 4/2/24 at 10:15 AM, of a computer that was located on a medication cart on the Alzheimer's unit revealed the computer was opened with Resident #66's EMAR information visible on the screen. Licensed	F 583	* On April 4, 2024, the Director of Nurse provided education to Licensed Nurse #2 related to safeguarding the privacy of Protected Health Information of Resident #66. * Residents have the potential to be affected by this practice. * April 4, 2024, the Staff Development Nurse and the Director of Nurses provided education to the Licensed Nurse and Certified Nurse aides related to the protection of Private Health Information of the Residents. An Ad Hoc Quality assurance meeting was held on April 5, 2024, to discuss the action plan and initiation of audits. * Beginning on April 4, 2024, the Director of Nurses, the Staff Development Nurse, the Quality Assurance Nurse and the Minimum Data Set Nurses shall conduct audits for exposure of Protected Health Information, three (3) time per week for four (4) weeks, then two (2) time per week for two (2) weeks, then one (1) time a	

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F 583	Continued From page 2 Practical Nurse (LPN) #2 was in Resident #66's room and the screen was visible to anyone passing by the medication cart in the hallway. The visible information included Resident #66's name, medications, and room number. An interview on 4/2/24 at 10:18 AM, LPN #2 confirmed that the EMAR for Resident #66 was visible on the screen to anyone walking by and should be closed when she was away from the medication cart to secure private health information. She stated "I have to remind myself every day to close the screen before stepping away from the cart." LPN #2 confirmed that this is a violation of keeping the resident's medical records private and a Health Insurance Portability and Accountability Act (HIPAA) issue. An interview on 4/02/24 at 10:50 AM, the Director of Nursing (DON) confirmed that a resident's information should never be left up on the computer screen while the cart is unattended. The DON stated "there is a privacy button that is supposed to be pushed before the nurse steps away from the computer." The DON confirmed this is a privacy issue and could result in a HIPAA violation. Record review of Resident #66's Admission Record revealed the resident was admitted to the facility on 11/30/2023 with diagnoses that included Alzheimer's Disease, Anemia, and Atherosclerotic heart disease.	F 583	week for two (2) weeks. The Administrator will take the results of the audits to the Quality Assurance Committee beginning on May 6, 2024, for two months.	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a	F 623		5/10/24

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F 623	Continued From page 3	F 623		

resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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F 623	Continued From page 4 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon	F 623		

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F 623	Continued From page 5 as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to send written notification to the resident and/or resident representative (RR) upon transfer to the hospital for two (2) of two (2) residents reviewed for hospitalization. Resident #30 and Resident #42 Findings Include: Review of the facility policy titled "Transfer and Discharge" with a revision date of 10/18/2022 revealed "...Policy Explanation and Compliance Guidelines: ... 4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand..." Record review of Resident #42's Progress note dated 02/22/24 revealed Resident #42 was found to be non-responsive to verbal or tactile stimuli and her oxygen saturation was 82%.... 911 was notified for transport to the Emergency Room (ER)... Resident #42 left the facility by ambulance on 02/22/24 at 6:20 PM.	F 623	* On April 16, 2024, written notifications were sent to Resident # 30, for the transfer on January 12, 2024, and Resident # 42, for the transfer on February 22, 2024, and / or their Resident Representative. * Residents who transferred or discharged to another facility or hospital/emergency department, have the potential to be affected by this practice. * On April 5, 2024, The Administrator provided education to the Social Service Director related to sending written notification to the Resident and/or Resident Representative when the Residents is transferred or discharged to another facility or hospital/emergency department. An Ad Hoc Quality Assurance meeting was held on April 5, 2024, to discuss action plans and audits.	

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F 623	Continued From page 6 Record review revealed there was not a written notification of transfer given to the family for Resident #42 dated 02/22/24 when she was transferred to the hospital. On 04/02/24 at 12:05 PM, in an interview with Director of Nursing (DON), confirmed that they were not mailing written transfer notifications to the residents' RR's when residents were transferred to the hospital. On 04/02/24 at 1:14 PM, an interview with Social Worker (SW), revealed that she did not have a copy of the transfer/discharge notification dated 02/22/24 on Resident #42, the date she was transferred out to the hospital. The SW revealed that she called the Responsible Party (RP) about bed hold only and confirmed that she had not been mailing the notice of transfer/discharge out to the RP. The SW stated, "I didn't realize I was supposed to be mailing them to the RPs, but will get them sent out from now on." Record review of Resident #42's "Admission Record" revealed that she was admitted on 01/22/24 and had diagnoses including Chronic Obstructive Pulmonary Disease, Muscle Wasting and Atrophy, and Dementia. Resident #30 Record review of the "Progress Notes" for Resident #30 revealed on 1/12/2024, the resident was transferred to the hospital for "...seizure like activity and unresponsive to verbal and physical stimuli...". An interview with the SW on 4/02/2024 at 11:20	F 623	for this deficient practice. * The Business office Manager or the Quality Assurance Nurse shall conduct audits of Residents who were transferred to another facility or hospital/emergency department to verify that a written notification was sent to the Resident and/or the Resident's Representative, four (4) times per week for four (4) weeks, then three (3) for two weeks and then two (2) times per week for two (2) weeks. The Administrator will take the results of the audits to the Quality Assurance Committee beginning on May 6, 2024, for two months.	

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F 623	Continued From page 7 AM, confirmed she had not mailed out a written notification of transfer/discharge to the RP for Resident #30. She revealed she was unsure who was responsible for doing that. An interview with the DON on 4/02/2024 at 12:02 PM, revealed that the nurses send out the written notification of transfer/discharge with the residents when they were transferred to the hospital. He confirmed they had not been mailing a copy to the RP. An interview with the Administrator (ADM) on 4/02/2024 at 12:07 PM, revealed he was not aware the written notification of transfer/discharge was not being mailed out to the responsible party's (RP) and confirmed it should have been. Record review of the "Admission Record" revealed the facility admitted Resident #30 on 12/28/2023 with medical diagnoses which included Seizures and Type 2 diabetes mellitus.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		5/10/24

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F 656	Continued From page 8 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to develop a care plan for a resident with a skin concern and Transmission-Based Precautions (TBP) for one (1) of 19 residents sampled. Resident #72	F 656	* The care plan of the resident identifier # 72 was reviewed by the Director of Nurses and it was found that the order for isolation had been discontinued by the physician on April 4, 2024,	

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F 656	Continued From page 9 Findings Include: Review of the facility policy titled "Comprehensive Plan of Care" with a revision date of 10/10/2022 revealed "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment..." Resident #72 Record review of the "Order Summary" for Resident #72 revealed an order dated 3/31/2024, "Contact Isolation due to MRSA (Methicillin Resistant Staphylococcus Aureus) to right hand". Record review of the "Order Summary" for Resident #72 revealed an order dated 4/03/2024, "Clean abrasion to right hand with ns (normal saline), pat dry, cover with small island dressing daily." Record review of Resident #72's "Care Plans" revealed a care plan was not developed for the skin concern on the right hand that required contact isolation. An interview with Registered Nurse (RN) #1 on 4/03/2024 at 2:10 PM, revealed she was responsible for the development of Resident #72's care plans. She confirmed that she did not develop the care plan related to the skin concern or contact isolation and stated that staff would not know what care to perform.	F 656	* Residents with orders for Isolation Precautions have the potential to be affected by this practice. * The Director on Nurses and the Administrator educated on the Minimum Data Set Nurses and Interdisciplinary Team on the Comprehensive Plan of Care Policy to emphasize the importance of ensuring care plans have been revised and updated accordingly. Isolation orders will be discussed in the clinical meetings with the Interdisciplinary Team. The Minimum Data Set team / Interdisciplinary Team shall conduct a 100% audit of isolation care plans of Residents with isolation precaution orders beginning on April 15, 2024. An Ad Hoc Quality Assurance meeting was held on April 5, 2024, to discuss the on-going action plan and auditing. * The Minimum Data Set Nurses team and Interdisciplinary Team will audit isolation care plans three (3) times a week for four (4) weeks and one (1) time a week for four (4) weeks. The Administrator will take the results of the audits to the Quality Assurance Committee beginning on May 6, 2024, for two months.	

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F 656	Continued From page 10 An interview with the Director of Nursing (DON) on 4/03/2024 at 2:50 PM, revealed the purpose of the care plan was for staff to know how to properly care for the resident. Record review revealed the facility admitted Resident #72 on 2/27/2024 with medical diagnoses that included Alzheimer's disease and Major depressive disorder.	F 656		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		5/10/24

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but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to use the appropriate Personal Protective Equipment (PPE) while providing care for a resident on contact isolation and failed to dispose of contaminated linens and trash into the designated biohazard containers in the room for one (1) of four (4) residents reviewed for Transmission-Based Precautions (TBP). Resident #72 Findings include: Review of the facility policy titled "Transmission-Based Precautions" with a revision date of 10/10/2022 revealed "Policy: It is our policy to take appropriate precautions to prevent the transmission of pathogens based on the pathogens' modes of transmission...Policy Explanation and Compliance Guidelines: ... 8. Contact Precautions- ... c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions, that may involve contact with the resident or potentially contaminated areas in the resident's environment. d. Donning personal protective equipment (PPE) upon entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination..." Resident #72 An observation outside Resident #72's door revealed a sign "Contact Precautions -apply gown	F 880	* On April 3, 2024, The Director of Nurse provided education to Certified Nurse Aide #1 and Certified Nurse Aide #2 related to contact precaution procedures when providing care to a Resident with an order for contact isolation. * Residents with orders for contact isolation have the potential to be affected by this practice. * On April 4, 2024, The Director of Nurses, the Staff Development Nurse, the Infection Prevention Nurse, or the Quality Assurance Nurse provided education to the Licensed Nurses and Certified Nurse Aides related to the use of contact precaution procedures when providing care to a Resident with an order for contact isolation. An Ad Hoc Quality Assurance meeting was held on April 5, 2024, to discuss action plans and audits for this deficient practice. * Beginning on April 5, 2024, the Director of Nurses, the Staff Development Nurse, the Infection Prevention Nurse, or the Quality Assurance Nurse will conduct audits related to staff utilizing contact precautions, four (4) times per week for four (4) weeks, three (3) for two weeks and then two (2) time per week for two (2) weeks. The Administrator will take the results of the audits to the Quality Assurance Committee beginning on May 6, 2024, for two months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255320	A. BUILDING _____ B. WING _____	04/04/2024

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F 880	Continued From page 13	F 880		

and gloves." Observed a designated plastic container outside the room door with the required PPE that included gown and gloves. An observation inside the resident's bathroom revealed two (2) biohazard containers designated for linen and trash disposal.

Record review of the "Culture Miscellaneous with Stain" dated 3/27/2024 revealed Methicillin Resistant Staphylococcus Aureus (MRSA) of wound drainage for Resident #72.

Record review of the "Order Summary" for Resident #72 revealed an order dated 3/31/2024, "Contact Isolation due to MRSA to right hand".

An observation of catheter care for Resident #72, on 4/03/2024 at 9:55 AM, with Certified Nurse Aide (CNA) #1 and #2 revealed, they entered the resident's room and did not apply a gown. CNA #2 performed catheter care with the assist of CNA #1. Following the completion of catheter care, they turned the resident over on his side and changed his brief, repositioned the bed pad and pulled the resident up in the bed. CNA #2 gathered the soiled linen and trash in clear trash bags, exited the room, and threw them into the dirty linen and trash container on 200 hall.

An interview with Certified Nurse Aide (CNA) #2 on 4/03/2024 at 10:20 AM, revealed she spoke with the charge nurse on Sunday 3/31/2024 and was told that the resident was "contagious," but she did not have to wear a gown. She confirmed that she read the sign outside the resident's door that indicated to wear a gown but did not think anything about it. She stated she knew to place the linen and trash in the biohazard containers in the room but got nervous and messed up. CNA

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F 880	Continued From page 14	F 880		

#2 revealed the purpose of separating the linen and trash from other residents was to prevent the spread of infection throughout the facility.

An interview with the Director of Nursing (DON) on 4/03/2024 at 10:35 AM, revealed for a resident in contact precautions, the staff were expected to dress out in a gown and gloves. He stated the linen and trash were to be discarded in the room to prevent the spread of infection to others in the facility.

An interview with the Infection Preventionist (IP) on 4/03/2024 at 10:39 AM, revealed the resident was in contact isolation for MRSA on the right hand. She revealed it was the facility policy to start contact precautions when a culture came back with MRSA. She explained that the staff were expected to wear gowns while providing care. The IP revealed the linen and trash should have been disposed of in the biohazard barrels in the room to prevent the spread of infection.

Record review revealed the facility admitted Resident #72 on 2/27/2024 with medical diagnoses that included Alzheimer's disease and Major Depressive disorder.